

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036691

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

FILED OCT 3 1962

Primary Registration District No.

1003

Registrar's No.

9351

VS 300
Rev. 4/59

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USE BLACK INK
OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

Deaconess Hospital

Inside Limits
Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

admission)

c. CITY
OR
TOWN

St. Louis

Inside Limits
Yes ☐ No ☐d. STREET
ADDRESS

3543 Humphreys

Reside on Farm
Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

Middle

Last

William

E.

Schrader

4. DATE
OF
DEATH

Month

Day

Year

Sept.

28

1962

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒Never Married ☐Widowed ☐Divorced ☐

8. DATE OF BIRTH

9. AGE (last birthday)

77

IF UNDER 1 YEAR

IF UNDER 24 HR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Belleville Illinois

12. CITIZEN OF WHAT COUNTRY

U. S.

13a. FATHER'S NAME

Henry Schrader

13b. MOTHER'S MAIDEN NAME

Louise Winters

14. NAME OF HUSBAND OR WIFE

Bertha Schrader

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Bertha Schrader 3543 Humphrey

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC INSUFFICIENCY

INTERVAL BETWEEN ONSET AND DEATH

1 Mo

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

COMPLETE HEART BLOCK

1 Mo.

DUE TO (c)

ARTERIOSCLEROTIC HEART DISEASE

1955

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

420.0

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes☐ No☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

a.m.

Month, Day, Year

p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

Nov 20, 1954 to

SEPT 28, 1962

and last saw him

alive on

SEPT 28, 1962

Death occurred at

SEPT 28, 1962

11:45 a.m.

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

M.D.

22b. ADDRESS

3543 Humphrey

22c. DATE SIGNED

9-28-62

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

OCT 1-1962

23c. NAME OF CEMETERY OR CREMATORY

Sunset Burial Park

23d. LOCATION (City, town, or county)

St. Louis

(State)

24. FUNERAL DIRECTOR

ADDRESS

Bonsieck-Nichols Mort. 1431 Union

25. DATE RECD. BY LOCAL REG.

SEP 28 1962

26. REGISTRAR'S SIGNATURE

E. Smith M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 3653

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is, not embalmed, fact should be so stated above.